LONGNER
Chiropractic

CONSENT FOR TREATMENT OF MINOR

Date: _____

I hereby authorize: Dr. Martin E. Longner DC

and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____ _____
Minor Patients Full Name D.O.B

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

Parent Remarks: _____

_____

_____

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